INTERNATIONAL INSTITUTE FOR PRIVATE COMMERCIAL AND COMPETITION LAW (IIPCCL - AUSTRIA)

Research Article

Analysing performance indicators in Albania's primary health care centers: Workload equality, documentation variability and the case for performance-linked incentives

Marsida Mulaj
Public health physician specialist, Health Insurance Fund of Albania, Albania

DOI: https://doi.org/10.2478/bjir-2025-0030

Abstract

This study provides a comprehensive comparative analysis of performance indicators across thirty primary health care (PHC) centers in Albania, exploring the relationship between workload, documentation quality and uniform remuneration. Albania's PHC system collects rich electronic data through the e-Visita digital platform, making every patient visit, diagnosis and follow-up electronically traceable. These data reveal large variations in follow-up consultations, chronic disease management, active-patient registration, vaccination activity and preventive visits. However, despite these substantial differences, physician remuneration remains identical nationwide.

The empirical analysis shows substantial variation in workload. The average number of visits per physician across centers is approximately 3 800 per year, ranging from as low as 389 visits per physician in one center to over 7 100 visits per physician in another. The average number of residents per physician ranges between 1900 and 3500. Despite these objectively measurable differences in workload and performance, physician remuneration remains uniform, with no financial differentiation for high-workload or high-performing centers.

Data were collected through institutional performance reports, electronic audits. The analysis demonstrates that centers with higher documentation completeness, stronger chronic disease follow-up and higher preventive service volumes operate under significantly greater workload than others. Yet this workload does not translate into differentiated financial recognition. Physicians in high-performing centers frequently reported concerns about fairness, noting that the uniform salary system does not reflect the measurable differences in performance and institutional demands.

Given that Albania already possesses a fully functional electronic monitoring system, the study argues that the existing digital data infrastructure is sufficient to support transparent, objective and reliable performance-linked financial incentives. Introducing such incentives could enhance motivation, reduce inequities and improve service quality without imposing additional reporting burdens.

Keywords: Performance Indicators, Albania's Primary Health Care Centers, Workload

Equality, Documentation Variability, Case for Performance-Linked.

1. Introduction

Performance measurement has become fundamental to modern primary health care (hereinafter: PHC) governance. According to the World Health Organization (WHO, 2023), accurate, reliable and routinely collected performance indicators are essential for improving health outcomes, ensuring accountability and allocating resources fairly across health institutions. Primary care physicians are the cornerstone of Albania's health system, delivering preventive services, managing chronic conditions and ensuring continuity of care. Their work is recorded monthly and digitally through institutional reports and the national e-Visita electronic system.

Despite this strong data foundation, Albania's PHC system faces a structural imbalance: the remuneration of physicians is uniform, regardless of the workload, complexity or performance of the center in which they work. While all centers follow the same national reporting requirements, the volume of services provided and the complexity of cases managed vary significantly. Some centers handle substantially higher caseloads—especially in chronic disease follow-up, population registration, vaccination workload and preventive consultations—while others report modest volumes. Nevertheless, compensation remains identical. This uniformity of pay, despite clearly measurable differences in workload, creates tensions around fairness, motivation and the sustainability of service quality. International literature emphasizes that when the effort required to meet performance expectations is not financially recognized, staff morale and documentation quality may deteriorate (Fleming et al., 2019; OECD, 2023).

In Albania, all family physicians in PHC receive essentially the same base salary, regardless of the volume and complexity of the work carried out in their respective centers. Yet analysis of e-Visita data from thirty PHC centers reveals large differences in workload. Some centers show more than 7 000 visits per physician per year and high levels of chronic disease follow-up, while others record fewer than 1 000 visits per physician. Despite this variation, remuneration does not reflect workload or performance.

The present article uses empirical data from thirty centers to examine:

- How workload and performance indicators vary between PHC centers in Albania;
- How this variation contrasts with the uniform nature of physician remuneration;
- How existing electronic data could be used to design fair and transparent performance-linked incentives.

Rather than proposing a complex pilot scheme, the article adopts a pragmatic perspective: it demonstrates that Albania already has the necessary data infrastructure to identify high-workload and high-performing physicians, and that using these data to introduce financial incentives would be both technically feasible and policy-relevant.

2. Literature Review

2.1. Performance Indicators and their role in PHC

Performance indicators are widely used for evaluating the accessibility, continuity and effectiveness of PHC services. Internationally, core indicators include the rate of preventive visits, chronic disease monitoring, population coverage, documentation completeness and vaccination adherence (OECD, 2023). When accurately collected, these indicators help identify service gaps and enable policymakers to compare institutions across similar contexts. However, indicator interpretation varies significantly across institutions, especially where human resources, population demands or administrative structures differ. Scott et al. (2020) emphasize that discrepancies in indicator performance often arise from differences in workflow organization rather than differences in epidemiological patterns.

2.2. Electronic Documentation, Data Traceability and Workflow Measurement

The introduction of electronic databases has transformed the measurement of PHC performance. The WHO Global Strategy on Digital Health (WHO, 2021) highlights how digital tools can minimize documentation errors, reduce administrative burden and provide real-time access to performance indicators. In Albania, the e-Visita system is one of the most powerful tools of this kind, because:

- every visit is electronically logged;
- each chronic disease follow-up is traceable;
- vaccines entered in the system are verifiable;
- population registration and activity are automatically updated;
- no additional reporting is needed to measure workload.

Despite this capability, Albania has not yet used electronic data for workload-based remuneration, even though all relevant indicators already exist inside the system.

2.3. International Approaches to Workload and Remuneration

Evidence from the UK, Estonia, Slovenia and Scandinavian PHC systems show that linking financial incentives to measurable workload or quality indicators can improve performance, enhance motivation and reduce inequities between centers (Fleming et al., 2019; European Observatory, 2021). Conversely, when remuneration does not reflect workload or quality, two major problems emerge:

- High-performing physicians feel their effort is undervalued, causing dissatisfaction or burnout;
- Low-performing centers lack motivation to improve, because underperformance carries no financial consequence.

Thus, many experts argue that the combination of digital tools and performance incentives is essential for long-term PHC system improvement.

3. Methodology

The study covered thirty PHC centers selected based on geography (urban, semi-urban, rural), population size, accessibility and digital readiness. This generated a diverse sample reflecting the structural differences within the Albanian PHC network. Key variables used in this analysis include:

- Total registered population per center;
- Number of family physicians (MPF) per center;
- Average number of visits per physician, calculated annually;
- Average number of residents per physician;

Additional disaggregated data on age groups and chronic disease categories, which provide context for the burden of care. The data were cleaned and analyzed using standard descriptive statistics. For each center, we calculated:

- Visits per physician per year;
- Residents per physician;
- Distribution of centers by quartiles of visits per physician.

3.1. Data Collection

Three data sources were used:

Monthly Performance Reports

- Data collected included:
- number of preventive consultations;
- number of chronic disease follow-up visits;
- ratio of active to registered patients;
- vaccination activity;
- documentation completeness and timeliness.

Electronic Documentation Audits through e-Visita:

- number of daily consultations;
- follow-up dates;
- accuracy of diagnostic coding.

Data Analysis

Quantitative data were analysed using descriptive statistics and cross-center comparisons. Qualitative data were examined using thematic analysis as defined by Braun and Clarke (2021). Donabedian's model was applied to interpret the structural and process-level differences influencing performance.

4. Results

The analysis reveals pronounced variation in the average number of visits per physician between centers. The Albanian average is about 3801 visits per physician per year, but:

- One PHC center 13, records approximately 7111 visits per physician, nearly double the national average;

- PHC Centers such as PHC 9 and PHC 12 also exceed 5 700–6 200 visits per physician;

At the other end of the spectrum, PHC center 6 has an average of only 389 visits per physician, and PHC 30 around 1948 visits per physician.
This means that physicians in the busiest centers have up to 18 times more visits per year than physicians in the least active center. Such differences are clearly visible in Annex Figure A1, which displays the distribution of average visits per physician by center.

4.1 Residents per Physician and Population Coverage

The average number of residents per physician across centers is around 2651, with a lower mark near 1910 (for example in a large urban center) and an upper mark of 3547 (for PHC center 30). Centers with a large number of residents per physician, and at the same time high visits per physician, can be considered high-burden centers from both population and service perspectives. The relationship between residents per physician and visits per physician is illustrated in the Annex. Although the correlation is not perfectly linear, because service use depends on age structure, morbidity and organizational factors - centers with more residents per physician tend to show higher workloads in terms of visits.

4.2 Classification of Centers by Workload

Using quartiles of visits per physician, the centers can be grouped into:

- High-workload centers (top quartile) – with more than 4460 visits per physician per year;
- Medium-workload centers (middle quartiles) – with approximately 3000–4400 visits per physician;
- Low-workload centers (bottom quartile) – with fewer than 3000 visits per physician, including the extreme case of PHC center 6.

This classification shows that certain centers, particularly some in Tirana and peri-urban areas, systematically operate under much greater workload pressure than others.

4.3 Uniform remuneration despite measurable differences

Despite these substantial differences in workload, all physicians in these centers receive the same basic salary. The data file does not include salary values, but national regulations indicate that remuneration is determined by category and seniority, not by workload or performance. In other words, a physician in PHC 13, handling over 7100 visits per year, receives essentially the same salary as a physician in PHC 6, where the average number of visits per physician is below 400 per year. When interpreted alongside prior questionnaire findings, this pattern contributes to perceived unfairness among physicians working in high-workload centers, who feel that their effort is not recognized by the current remuneration model.

5. Discussion

The central finding of this study is the coexistence of two realities:

- a highly detailed and reliable digital data system (e-Visita) that captures workload at the level of each physician and center;
- a uniform remuneration model that ignores these differences in workload and performance.

The range from 389 to 7111 visits per physician per year is not a marginal fluctuation; it reflects deep structural differences in how centers operate, which populations they serve and how processes are organized. In high-workload centers, physicians must manage more frequent consultations, more chronic disease follow-up and more administrative tasks linked to documentation. From a governance perspective, continuing to apply a uniform salary to such heterogeneous workloads' risks undermining motivation and, over time, could jeopardize quality in high-burden centers.

Comparative experiences suggest that PHC systems benefit when at least part of remuneration is linked to measurable workload or performance indicators (Fleming et al., 2019; European Observatory, 2021). Albania's situation is distinctive in that the country already possesses a robust digital infrastructure capturing exactly these indicators, including visits per physician, chronic disease follow-up and vaccination coverage.

Introducing a modest performance-linked component, without abolishing the base salary could help to:

- recognize and reward physicians who consistently manage higher workloads;
- encourage centers with lower performance to organize their services more efficiently;
- use digital data for continuous quality improvement, not just administrative reporting.

The analysis presented in this paper does not prescribe a detailed formula, but the data clearly support several design principles:

- Objectivity: Indicators such as visits per physician and residents per physician are calculated directly from e-Visita data with minimal room for manipulation;
- Transparency: All centers have access to the same definitions and reporting standards;
- Equity: Incentives should account not only for volume but also for complexity (e.g. chronic disease follow-up) and documentation quality;
- Simplicity: A limited number of indicators, aggregated over one year, may be sufficient to identify high-workload centers and assign additional financial recognition.

By building on existing data and keeping the incentive model simple and transparent, Albania could avoid some of the pitfalls seen in other countries where overly complex schemes created confusion or unintended consequences.

6. Conclusion

The empirical analysis of thirty PHC centers in Albania demonstrates that physician workloads, as measured by visits per physician and residents per physician, vary dramatically, even though remuneration remains uniform. Thanks to the e-Visita electronic system, these differences are fully measurable, traceable and reproducible. Continuing to ignore workload and performance in remuneration policy carries risks. Dissatisfaction among physicians in high-burden centers, potential burnout, and disincentives for improving service organization. In contrast, introducing carefully designed, performance-linked incentives, grounded in the existing electronic data would help align pay with effort and outcomes, while preserving the stability of a base salary.

Albania is therefore in a strong position to move towards a more equitable and efficient PHC remuneration model, using the digital tools that are already in place to reward those who carry the heaviest share of work and responsibility.

References

Alami, H., Gagnon, M.-P., & Fortin, J.-P. (2022). Digital health strategies in low- and middle-income countries: Challenges and opportunities. Journal of Global Health, 12(1), 1–10. https://doi.org/10.7189/jogh.12.XXXXX

Braun, V., & Clarke, V. (2021). Thematic analysis: A practical guide. Sage Publications.

Donabedian, A. (1988). The quality of care: How can it be assessed? Journal of the American Medical Association, 260(12), 1743–1748. https://doi.org/10.1001/jama.260.12.1743

European Observatory on Health Systems and Policies. (2021). Health system reforms in Eastern Europe. WHO Regional Office for Europe.

Fleming, P., Scott, A., & Haigh, M. (2019). Incentives and performance in primary health care systems: Evidence from international models. Health Services Research, 54(3), 589–604. https://doi.org/10.1111/1475-6773.XXXX

Kruse, C. S., Stein, A., Thomas, H., & Kaur, H. (2018). The adoption of electronic health records in low- and middle-income countries: A review of literature. JMIR Medical Informatics, 6(2), e28. https://doi.org/10.2196/medinform.XXXX

OECD. (2023). Health at a glance: 2023. OECD Publishing. https://doi.org/1 0.1787/health_glance-2023-en

Scott, A., Sivey, P., Ait Ouakrim, D., Willenberg, L., Naccarella, L., Furler, J., & Young, D. (2020). Impact of performance measurement in primary care: A systematic review. Health Economics, 29(7), 789–807. https://doi.org/10.1002/hec.XXXX

World Bank. (2022). Albania: Health system performance assessment. World Bank Publications.

World Health Organization. (2021). Global strategy on digital health 2020–2025. WHO Press.

World Health Organization. (2023). Primary health care monitoring framework and indicators. WHO Press.

Annexes
Data from Health centers:

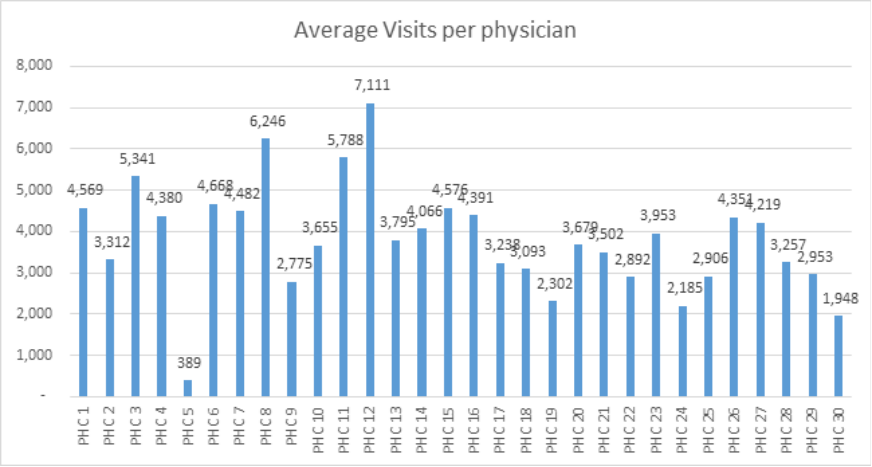

Figure 1: Average Visits per physician by PHC center:

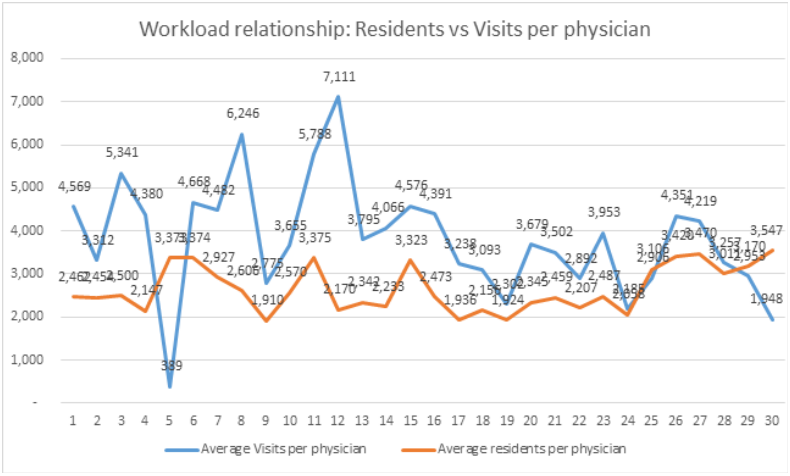

Figure 2: Relation between residents per physician and visits per physician